

South Africa Learning Alliance for District Health Systems (SALAD)

Capitation-based financing for primary care:

learning lessons from the ground-up to strengthen the NHI

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Speakers:

Susan Cleary: Head of Department and Professor of Health Economics in the School of Public Health, University of Cape Town

Plaxcedes Chiwire: Health Economist: Health Intelligence, Western Cape Government Health & Wellness

Panelists:

Simon Kaye: Head of Corporate Service Support, Western Cape Department of Health and Wellness

Barry Childs: Group CEO Insight Actuaries and Consultants

Moremi Nkosi: Chief Director: NDoH Healthcare Benefits and Provider Payment Design

Shabir Moosa: Family Physician, HOD Clinical Unit for Family Medicine, Johannesburg Health District

Introduction

This webinar forms parts of a series of online engagements hosted by the South African Learning Alliance for District Health Systems (SALAD). SALAD is a community of practice which facilitates dialogue between a diverse range of players on key issues in district health systems strengthening.

This webinar was motivated by discussions in different quarters on the ongoing health reforms in South Africa, with a focus on how these reforms will be financed.

PART I

Susan Cleary provided an overview of capitation-based financing mechanisms vis-à-vis the current health reforms in South Africa.

Different types of capitation:

1. Capitation as a mechanism to enable an **'equitable share'** of a budget to a geographical area
2. Capitation as a mechanism to **pay providers**

In the current system, the National Treasury allocates revenue to the nine Provincial Treasuries using the provincial equitable share formula (PES). The respective provinces then have discretion on how they allocate these resources to Health which can lead to variations in per capita spending. On average, Provincial Departments of health receive approximately 33% of the entire PES. Provincial departments then allocate funding to district health services and hospitals (provincial, regional and some tertiary level). Allocation is usually historical in nature.

When capitation is used as a **mechanism to pay providers**, service providers are paid a set amount of money for a set period of time for each user registered under their care. For 'risk-adjusted capitation',

service providers are remunerated based on the characteristics of the health user for e.g., a provider would be paid a higher rate for an older person registered in their facility than a younger person, irrespective of the care actually used.

Under the proposed NHI model, the health component of the current Provincial Equitable Share would flow directly from the National Treasury to the NHI fund and no longer flow via Provincial Treasuries. The NHI fund then becomes the sole buyer of health services – the ‘single purchaser’.

The relevant legislation from the NHI Act refers:

Section 35:

‘Funds for primary health care services must be reimbursed directly to accredited and contracted primary health care service providers and health establishments’

Section 37:

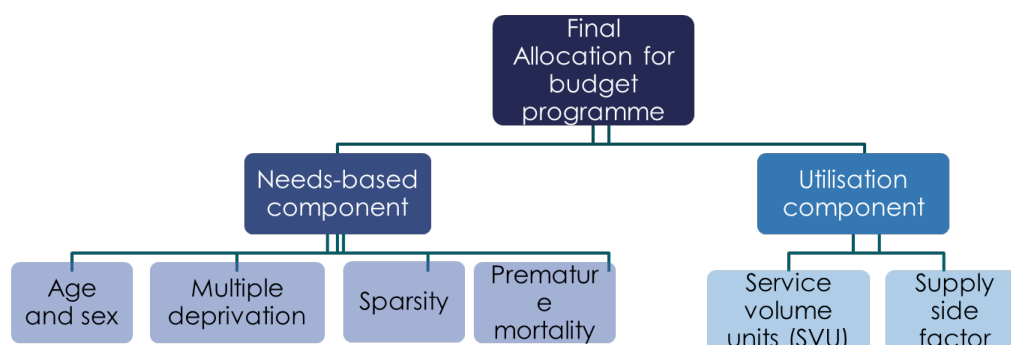
‘An accredited primary health care service provider or health establishment providing primary health care services must be reimbursed by the Fund in accordance with the prescribed capitation strategy’

Ensuring an ‘equitable share’ of a budget to a geographical area

Regarding the first form of ‘capitation funding’, **Plaxcedes Chiriwa** described the experiences in the Western Cape of developing a geographical resource allocation model that will improve equity and deliver more value. This model is similar to the health formula used in the Provincial Equitable Share calculation and hence is informed by population and health needs.

This approach enables a move away from **historical budgeting**. The latter is considered to be inequitable and inefficient because it does not acknowledge changes in population and health needs. She illustrated this by comparing the difference in allocations using historical budgeting versus population-adjusted health need.

The flow chart below illustrates the division of resources based on needs versus utilization and the respective metrics that inform both of these.



To determine the needs-based component, this model uses the same metrics as the Provincial Equitable Share formula.

Risk adjustment is then applied to the four needs-based metrics across all districts and sub-districts to determine an estimated population health-need.

A comparison between the application of historical budgeting versus ERA reveals the potential inequities in existing historically based district allocations.

Part II of the webinar involved a panel discussion. Questions were posed to the panellists and their responses are shared below.

Question 1

The ERA focuses on equitable resource allocation at the sub-district or district level, using a risk adjusted capitation approach.

What do you think are the **key challenges to implementation**?

Simon Kaye outlined **three challenges** at the district level which can influence implementation.

- **Data sets.** What is available and not available? The ERA model was adapted for the WC context but used national data sets.
- **Capacities and capabilities.** It is important to have the right people in the right places.
- **Behaviours.** Change management is difficult especially when people are allocated fewer resources however having a model that justifies the new allocation does help with change management. It is much more difficult to accept lower allocations at the facility level because of the lack of flexibility at this level rather the sub-district and district levels.

Barry Childs stated that it is important to recognise that people do not necessarily access health services based on geographical boundaries and thus this is one limitation in implementing ERA at a district and especially at a sub-district level. He added that it is important to monitor allocated budget versus what is actually spent and to monitor expected utilization versus actual utilization.

Shabir Moosa commended the ERA as a means of addressing inequity, but argued that relying strongly on population is concerning as it is likely to change rapidly. We need to look beyond factors like geography and population, to individual risk adjusters. He noted that the current factors such as age and sex can be built on to include other factors such as rurality, social economic status etc. The risk of having too many providers in a pool (i.e. allocating resources to a district vs facility/provider) may be a disincentive for providers to sign up.

Moremi Nkosi reiterated the need for quality data and that the intention of NHI is to go down to the facility level. He also echoed Shabir's sentiments of having too many providers and responded that there is a need for good change management. He also remarked on the issue of a mobile population.

Question 2

In addition to this idea of using a risk-adjusted capitation approach to assign a sub-district or district level budget, the NHI also proposes a capitation model for provider payment – i.e. capitation-based payments to clinics or GP practices.

What do you think would be the extra equity or efficiency benefit of taking capitation down to the provider level?

- What would be the risks?
- How will this be extended to include other providers e.g. rehab providers?

Simon noted that the ERA model that was described earlier by Plaxcedes can go down to the facility level. Capitation-based financing is appropriate at a primary care level but not hospital level. Simon proposed a mixed model which would include a capitation/risk adjusted fee, fee-for-service and pay for performance models.

Barry highlighted a few payment models that are being trialled in the private sector. With regards to primary care and in the case of GPs, these include full capitation models, fee for service and a hybrid of the two models (half capitation, half fee for service). In terms of equity, the primary gain from the NHI is at the macro level since the state becomes the sole purchaser which allows it to buy services from the private sector to supplement public health services and to make these available to the entire population.

In contrast, **Shabir** stated that the objective should be on achieving equity at the individual level and reemphasised the need for individual risk-adjusted factors that will result in an individual budget based on individual-specific criteria.

Moremi stated that funds will be allocated directly to providers or facilities. The provider is responsible for how the money is utilised for the population they are responsible for. Efficiency will be achieved by patients registering with service providers. The goal is to structure multi-disciplinary teams starting off with GPs and nurses. This will result in patient-centric care and rationalising of services. Provider contracting will require appropriate metrics. Strong monitoring and evaluation is important and appropriate indicators must be determined for provider contracting. Shadow contracting will identify gaps and thus equity gaps can be addressed progressively.

The discussion encouraged questions and comments from the audience. We have shared them below:

- a) How will the principal-agent problem be addressed? Can resource allocation that is taking place at national level understand local realities?

The CUP is meant to be a proactive representation of the fund at the sub-district level that engages with the DHMO. Any problems with regards to services provided will be addressed with the service provider with oversight at the national level.

- b) Will patients have a choice of providers?

Users have the discretion of registering with a service provider of their choice. When the user moves, funding will be allocated to the new service provider.

- c) How will the other health care providers be reimbursed? Will they be part of the capped fee or separate?

The first 3-5 years will focus on GPs and nurses. The other providers will be progressively included into the multidisciplinary team and will be remunerated using a different approach.

- d) How will the funding split be determined?

- It is the responsibility of the group practice to decide on this.

e) Will funding flow directly to public providers/facilities?

No, not the way public service is currently structured. There will be different reimbursement models which have yet to be determined.